BULLETIN

Founded 1872

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Founded 1872

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How Things Work

"The people who are making the laws are well aware of our problems but are unsympathetic in their actions towards medical providers."

James A. Lambert, MD

I recently had the opportunity to participate in a "Washington Fly-in" with the Stark County Medical Society under the sponsorship of the 16th District Congressman, the Honorable Ralph Regula. Among those meeting with the group were representatives Richard Gephardt from Missouri, Fortney "Pete" Stark from California and Willis Gradison of Cincinnati. Robert Eaton, an associate administer for HCFA, also made himself available for questioning. The meetings were enlightening for what they revealed in the ways things work in Washington, D.C.

CONGRESS

The most impressive thing for me was the obvious awareness by the congressmen of the problems facing medicine. Even though representatives Gephardt, Gradison and Regula appeared generally sympathetic with the plight of physicians in regard to health care, they obviously did not have solutions that would be satisfying for physicians.

Representative Stark is Chairman of the Subcommittee on Health of the House Ways and Means Committee. He is obviously well aware of the controversy surrounding his actions as chairman of that subcommittee. He responds quickly to questions posed by probing physicians by quoting the various statistics that the physicians plan on using in their attack on his programs. His point is that regardless of the background circumstances there are going to be changes made in regard to quality assurance and payment under Medicare. The physician reimbursement for Medicare has been increasing at close to 15% per year. This is an aggregate expense which means that the total amount spent on Medicare has gone up that much and does not reflect the payments received by individual physicians. In order to control this, he is proposing a 3 part concept consisting of:

1. a reasonable rate structure implemented across the country
2. some means to deal with expenditures, and
3. prohibition on transfer of cost reduction to the beneficiary.

He has also introduced a bill, H.R. 4464, which would require any physician who is treating Medicare patients to be board certified and re-certified every 7 years. The thrust of his proposals is clearly aimed at providers and physicians.

Representative Gradison, on the other hand, who also served on the Pepper Commission on comprehensive health care, does not project the same feeling as Representative Stark but does acknowledge that some actions will be forthcoming. He quoted public opinion polls that indicate Americans feel that universal health access is a right, but they are unwilling to pay for a National Health Service, are ambivalent on welfare plans, are reluctant to have the federal government run such a program, and do not believe that a National Health Service will lower cost. These were very perceptive observations and certainly obviated the need for stressing these points with the congressmen.

The problem is that some activity is being demanded from Congress and legislation will be forthcoming. This is the first step in the process. Congress makes the laws pertaining to Medicare.

HCFA

The next step in the process is interpretation and direction from HCFA. HCFA has the responsibility for trying to interpret the intent of Congress as manifested in the law. HCFA then notifies the PRO's in regard to implementation of review and the Medicare carriers in regard to payment procedures. Although HCFA gives the direction, the actual implementation does not appear to be monitored that closely. Many of the concerns expressed by the physicians in the group were obviously not known to Mr. Eaton. He took notes on the problems and promised follow-up as well as giving his telephone number and office address to physicians who desired further contact. The problem at the

bureaucratic level appears to be one of not knowing exactly how the regulations are being implemented.

IMPLEMENTATION

PRO — The PRO's have been lately admonished to concentrate more on quality of care and less on the financial aspects of medical treatment. The two big areas of concern are:

1. denial of admission, and
2. quality assurance.

The quality assurance area is the one of greatest concern for providers. Sanctions against physicians can include exclusion from Medicare, fines and other penalties. These sanctions can also be shared with the hospital in regard to different degrees of chart review prior to payment. Any quality letter from the PRO should be taken very seriously and discussed with the appropriate hospital authorities to structure a proper response. Responses should include some means of verifying that the PRO has indeed received the response.

CARRIERS — The insurance companies that administer the payment programs also carry out their own individual brand of implementation of the HCFA regulations. These problems include what codes to use for submitting claims and the notorious denial letters. There has been much debate and concern over the wording of the letters from the carriers to the physicians with copies to patients in regard to the potential for disrupting the patient-physician relationship. The problems created by the carriers, however, are not necessarily directly visible to HCFA and need to be called to their attention by the physician community.

SUMMARY

The conclusions to be derived from this information are disheartening. The people who are making the laws are well aware of our problems but are unsympathetic in their actions towards medical providers. The bureaucrats do not appear to have firm control over implementation of the regulations that they derive from Congress. The PRO's and carriers appear to be somewhat arbitrary in their implementation of HCFA's directives and frequently make changes in their programs without adequately informing the physicians and hospitals. Unfortunately, confronting the legislators with the facts does not appear to be a useful endeavor. Confronting HCFA, the PRO and the carriers allows us to function on a daily basis but does not address the root cause of our problem in Congress and the public perceptions. □

Revelation

It was raining and I was on my way to the office. Shortly after entering onto the freeway my wipers stopped. "Oh great!" I thought, "Now what?" I decided to continue the 20 minute trip in hopes the rain would stop. It didn't. I tried in vain to fix the wipers, pounding the dashboard, clicking the switch on and off — anything to make them work again. They didn't.

Visibility was poor at best. Luckily the traffic was mild and there was no construction. Exiting the freeway brought a sigh of relief until I began traversing Route 224. I never realized how much a little rain could cut ones vision. I rolled the window down in order to see the maze of cars ahead of me. The trip was slow but I made it to the office where I called the mechanic. He said to bring the car right in.

Pulling into the garage I realized how much I didn't like going there. I was obviously out of place with my high heels and skirt. I also felt like a babbling idiot trying to explain my rendition of what I thought was wrong with the car. Although the mechanic was polite I sensed a bit of skepticism in his manner.

"What seems to be the problem?" he said.

"Well, the wipers stopped working after about 10 wipes." I said.

"Oh, it's probably a fuse." he said.

"No, I don't think so," I replied. "I could hear the whirr-click of the wiper motor even though they weren't moving."

He gave me another skeptical glance and we went to the car where he immediately pulled and tinkered with the fuses, to no avail. Vindication! I am not dumb!

"Pull the car in," he said, "I'll have to look a little more."

I did as he said and stood in the garage as he went over various aspects of the car. I was thinking electrical parts are probably expensive and the car would be tied up for a while. As I was making mental plans on what to do he finally said, "Here it is."

The bolts that hold the wipers to the arm were loose. Once tightened the wipers worked perfectly. I breathed a sigh of relief and thanked him.

"No charge." he said.

This experience brought a myriad of feelings. Incompetence helplessness, stupidity. I did things like try to pretend the wipers would work if I just waited a little longer; turned some knobs to see if this would correct the problem.

Once I acknowledged there was a problem I was reluctant to seek help, but did so out of necessity. While explaining my car's "symptoms", I wasn't sure I was being listened to. I also felt some sense of victory when the mechanic was wrong. I was relieved and thankful that he found the problem and it wasn't as serious as I thought. Although the mechanic could have been more personable, I felt he was competent and would see him again if needed.

Looking back, the experience is a little frightening. I see my patients in my actions. Those who wait until the last minute with serious problems, thinking they will go away. I can understand better now why they would wait. How uncomfortable and difficult it is to confront an unfamiliar situation, or a familiar situation that makes one feel helpless or incompetent.

It's funny how seemingly trivial situations sometimes stand out. I'm only glad that the incident involved my car and not a family member with a life threatening illness. □

Denise L. Bobovnyik, MD

Mesenteric Embolism, Surgery vs Medicine Part II

Last month we discussed the case of a 50 year old male with acute abdominal pain, a history of rheumatic heart disease and long standing atrial fibrillation. There was a 20% prior probability of acute mesenteric embolism and the question was whether to observe and treat medically or operate immediately? A decision tree model was presented and expected utility values were calculated comparing surgery with medicine. The foldback data at the decision node was also presented. These values are reprinted for your convenience in the box below.

FOLDBACK DATA AT DECISION NODE
EU (SURGERY) = 17.37
EU (MEDICINE) = 16.04

The results appear to be a "close call" that favors surgical treatment. How were these values obtained? The method for calculating the expected values along any one management path (i.e. Surgery or Medicine) is referred to as averaging-out and folding-back. To accomplish

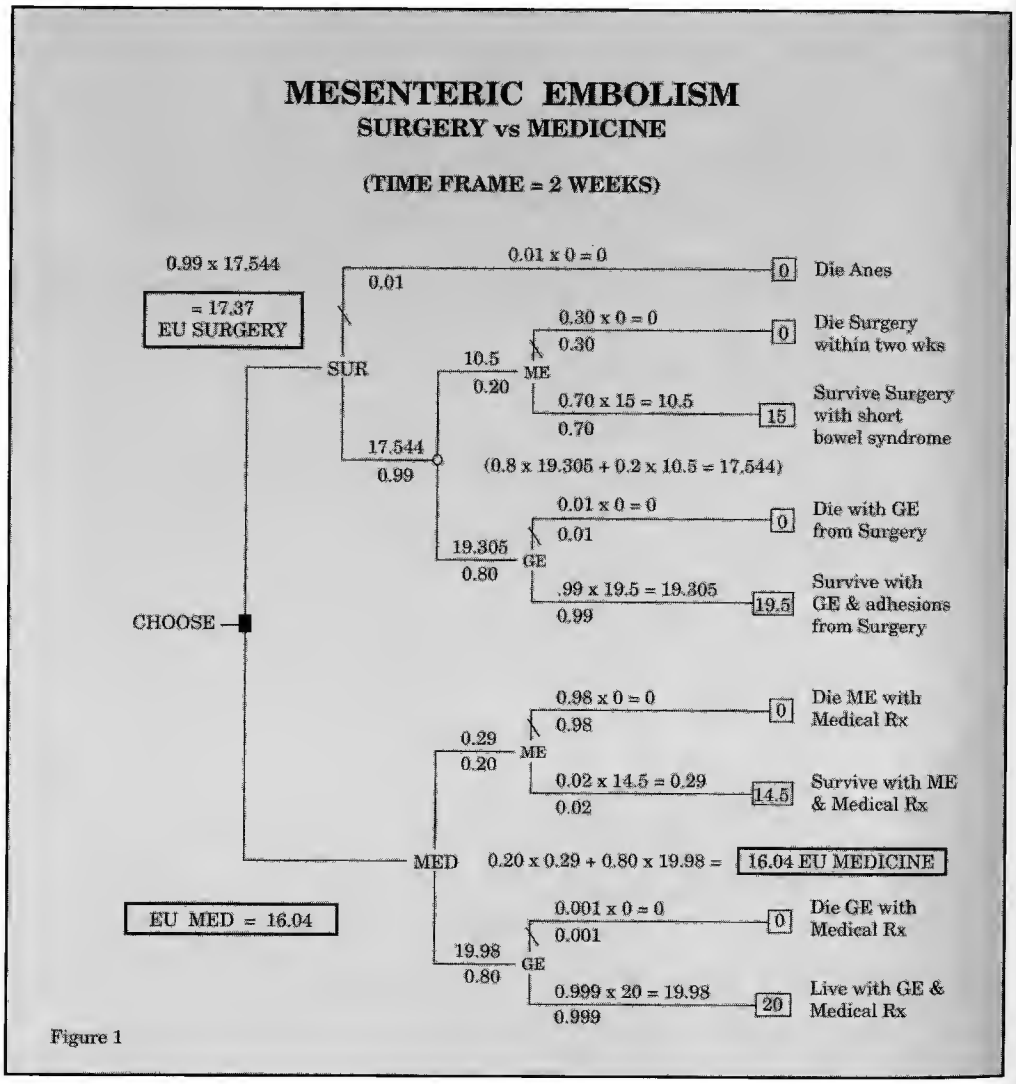
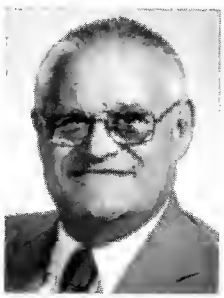


Figure 1



Leonard P. Caccamo, MD, FACP

Kimbroe Carter, MD

this process the tree is approached in a retrograde manner beginning at the leaves (utilities) and the terminal branches. The numbers in the boxes are the utilities, or values in life years gained by reaching the respective outcome of a particular pathway. In addition the probabilities of each outcomes at any chance node are mutually exclusive. The value, if you will, at a chance node is equal to the value of the outcome multiplied by the path probability immediately upstream toward the decision node. We hope you were able to obtain these same answers by manual calculations. If not, we have printed the decision tree in Figure 1 to illustrate how these values were obtained.

Since we obtained a close call we shall now explore the following "WHAT IF" strategy utilizing sensitivity analysis:

What if the physician's prior probability estimate is varied?

This question was explored with the use of Tufts Decision Maker Version 6.0 and a personal computer. Many hours of hand calculations can be saved and results rapidly produced with these valuable tools. The graph that follows in Figure 2 demonstrates one way sensitivity analysis and clearly illustrates even at very low prior probability of mesenteric embolism, just above the threshold of 0.079, the best management course is surgery. In order to answer this question the prior probability of mesenteric embolism was systematically varied along the X axis. The expected utilities or the years of life expectancy to be gained were calculated for the medical and surgical management strategies at each point along the X axis. A tree foldback was calculated for each probability point and the graph efficiently generated by the computer program.

When the Bulletin resumes publishing in the fall we shall answer the other two "WHAT IF" questions posed in our previous article. □

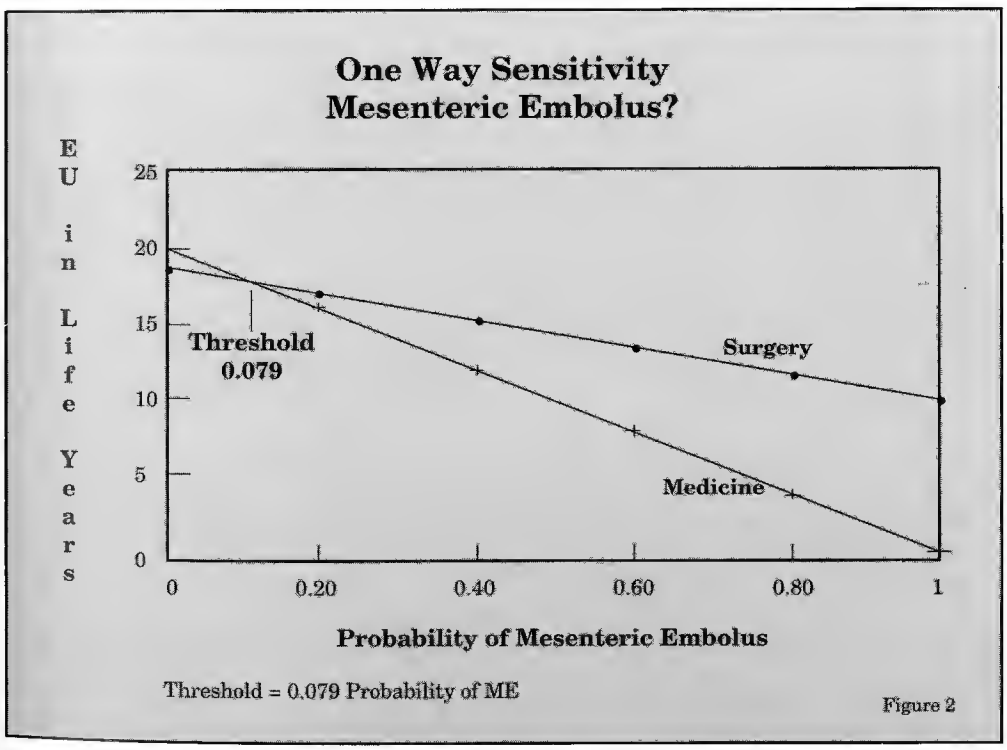


Figure 2

Medical Testimony By Physicians

A doctor asked me the other day if I had heard that they are starting to substitute lawyers for white rats in lab experiments.

"That so?" I said, rolling my eyes skyward in the face of the inevitable punchline.

"Yeah," he said, "They're a lot more plentiful — and you don't form those close emotional attachments..."

It goes without saying that physicians and attorneys enjoy taking digs at each other, and that, generally, the only time a doctor likes seeing a lawyer is when he gets teamed with one who is a significant sandbagger in the annual golf club parimutuel team event.

"Reluctance upon the part of physicians to give medical reports or testimony must be set aside if the physician is to fully perform his duties to his patients."

It is inevitable, though, that most physicians in the course of their careers will become involved in some aspect of the legal process. While it is true that, for a few, this comes in the form of a medical malpractice suit, for the vast majority of physicians it is when they are asked to give medical testimony on behalf of their patients in personal injury lawsuits. Unfortunately, physicians' understandable aversion to malpractice suits, sometimes translates into a disdain for dealing with lawyers in general, which in turn impinges on the ability of their patients to seek compensation for their personal injury claims.

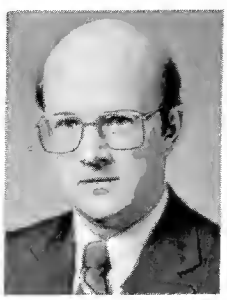
Reluctance upon the part of physicians to give medical reports or testimony must be set aside if the physician is to fully perform his duties to his patients. This proposition is recognized in the Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association.

> 9.07 MEDICAL TESTIMONY. As a citizen and as a professional with special training and experience, the physician has an ethical obligation to assist in the administration of justice. *If a patient who has a legal claim requests his physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.*
>
> The medical witness must not become an advocate or a partisan in the legal proceeding. The medical witness should be adequately prepared and should testify honestly and truthfully. The attorney for the party who calls the physician should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case. It is unethical for a physician to accept compensation that is contingent upon the outcome of the litigation.

A physician's first contact with a patient's attorney often comes in the form of a letter requesting a medical report for the patient. In response, a brief report is typically sent to the attorney and the physician hears nothing further. What usually has happened is as follows:

In most injury cases, the patient (the plaintiff) is seeking compensation from the defendant's insurance carrier. Such compensation is based upon medical costs, lost wages, diminution in earning ability, and past and future pain and suffering. The plaintiff's attorney and the insurance carrier's adjuster have been in contact since shortly after the injury occurred, with the attorney having provided the adjuster witness statements, traffic accident reports, lost wage statements, medical bills, etc.

At the point when the plaintiff is either back to normal, or stabilized, the attorney will request a medical report from the treating physician. Doctors should expect three things from the attorney when this happens: 1. an executed release from the patient authorizing the doctor to render the report; 2. either payment for the cost of the report or a commitment that such report will be paid for; and, if the patient has an outstanding bill with the physician; 3. a commitment that the attorney will apply any settlement or trial proceeds to the doctor's bill. It is to be noted that this promise does not conflict with the last sentence of paragraph 9.07 noted above,



Nils P. Johnson Jr., JD
Attorney Johnson is a partner in the Canfield law firm of Johnson and Johnson. He is a contributor to several publications, including Ohio Magazine.

since payment is not contingent upon the outcome of the litigation — *it is understood that the patient is ultimately liable for the doctor's bill, regardless of whether the legal claim is successful or not.*

Medical reports are undoubtedly *the most important* factor in fixing the value of a plaintiff's case in the eyes of an insurance adjuster. For this reason, attorneys must be careful to set forth in their request *exactly* what information they are after. Alternatively, physicians must realize that each injury case is different and, therefore, they should pay attention to what is being requested in the report. For example, if the patient had a back problem before the injury, the attorney will want the physician to carefully discuss what aggravating effect (if any) the auto accident had on that pre-existing condition. An additional example concerns future treatment. In a serious injury case, attorneys will want the physician to discuss the likelihood and cost of required future treatment. *Reports which are skimpy, haphazard or which fail to fully discuss a patient's past, present and anticipated problems can work to drastically and unfairly reduce the amount offered in settlement by the defendant's insurance carrier.*

As mentioned, the reason physicians usually hear nothing back from the attorney after the medical report is sent out is that the majority of claims are settled after the insurance adjuster receives a copy of the report. If such a settlement cannot be achieved, the plaintiff's attorney will proceed to take the claim to trial (normally in front of a jury).

It is unavoidable that a claim taken to trial will require additional input into the case by the physician. In court it is necessary for the plaintiff to prove by *medical testimony*: that injuries were a direct result of the accident; that the medical expenses incurred were reasonable and necessary; that the pain experienced by the plaintiff was based upon some significant trauma to the body caused by the defendant; and (if applicable) that the injury will impair the plaintiff so as to affect his earning ability and/or enjoyment of life.

Medical testimony can be given in one of two ways. First, the physician can appear at the trial to testify. The second, and more common, way, however, is to give a deposition. A deposition is sworn testimony before a court reporter which is either taken down on paper or recorded by videotape. While it is true that depositions are often less effective than live testimony, to accommodate doctors' busy schedules, attorneys will often forgo live testimony and use a deposition if requested.

Prior to giving a deposition, a doctor should expect to meet with the plaintiff's attorney to discuss the plaintiff's medical condition. More than one meeting may be required. The attorney should be well versed in the nature of the plaintiff's injuries and be prepared to give the physician a general outline of the questions that he will ask, *along with* the questions that defense counsel will likely be asking. The attorney and physician should be prepared to discuss both the strengths and weaknesses of the medical portion of the lawsuit. *While attorneys do not expect the practitioner to violate 9.07 above by being biased towards the patient, they do expect that the physician be attentive, prepared, and well versed in the patient's condition and treatment.*

One area of confusion for physicians who give testimony concerns the legal concept of "reasonable medical certainty." Probably most physicians would suppose that the term, "medical certainty" is an oxymoron, for perhaps the only *certain* medical eventuality is death. However, under the law if a plaintiff is to recover for certain injuries, it must be shown that such injuries were, "to a reasonable medical certainty", or *more likely than not,* caused by the defendant. For example, if a plaintiff had not experienced back problems prior to a severe auto accident, and if a CAT scan after the accident showed a ruptured disc, the physician would be expected to testify

that "to a reasonable medical certainty" the ruptured disc was caused by the rear end collision. The confusion doctors have with this term seems to center on the word "certainty". The patients attorney, thus, must carefully explain that this *legal* concept does not mean a 100% or even an 80% likelihood of causation. The physician is only being asked to opine if it is more likely than not (51%) that the condition was caused by trauma engendered by the defendant.

Once the physician's deposition is over, he should expect to be paid for the time involved in preparing for and in rendering his testimony.

In sum, if the patient's attorney does the proper job in preparing the physician for testimony, explaining the legal principles involved, and scheduling matters at convenient times, the physician's job can be fairly painless. Although giving legal testimony on behalf of a patient can be grudgingly seen as a necessary evil by the medical profession, it might also be viewed as the joining together with another professional to complete the healing process of the patient/client. In this sense, the medical and legal professions have much in common. After all, another doctor once told me that a lawyer is someone who flunked organic chemistry... □

D. Brent Mulgrew, J.D., Society Speaker

The managing director and counsel of OSMA, D. Brent Mulgrew J.D., spoke on "Facing the Challenge of Fee Review" when 85 members and guests met for the May 15, 1990 dinner meeting at Tippecanoe Country Club.

Dr. James Lambert, president noted that the Society will implement the fee review program. He announced the appointment of Dr. Denise Bobovnyik as chairman of the Young Physicians Committee and presented the application of Patricia Pearson, M.D. for resident membership. The next Society meeting is scheduled for Tuesday, September 18, 1990 at the Youngstown Club.

Exposure to Mirex in the Little Beaver Creek Documented: What is the Health Impact?

"Since mirex is strongly bioaccumulated in fatty tissue and very slowly eliminated, prolonged low level exposure may lead to significant body burdens."

In the latest phase of the Nease Superfund site investigation in Salem, the Ohio Department of Health has conducted a survey of Mahoning and Columbiana County residents living near the Little Beaver Creek, a stream that has shown evidence of fish and sediment contamination with mirex, an organochlorine pesticide produced by the Nease Chemical Company in the years before its closure in 1973. Some 700 questionnaires were distributed in the survey. Of the 200 returned, respondents were ranked by risk of exposure by such pathways as direct exposure to the creek through swimming or wading, ingestion of fish from the creek, consumption of produce grown in the creek littoral and occupational exposure in former Nease employees. Forty-two respondents were selected for biologic screening; 14 of these 42 individuals had detectable levels of Mirex in their blood, ranging from 0.25 to 2.2 parts per billion. Due to the unrepresentativeness of the sample, it is not possible to estimate the prevalence of mirex exposure in the area. However, it is prudent to assume that more than these 14 individuals have been exposed to the chemical. Consequently, area residents and some public officials have called for more widespread screening and even the creation of an exposure registry to track these individuals.

Mirex is a compound extremely resistant to degradation in the environment. Its estimated half-life in soil is greater than 12 years. Since the chemical is strongly absorbed to soil, a major route of movement from a contaminated waste site is through erosion and transport into stream waters as has occurred at the Nease site. Although data on human exposure is lacking, all animal studies of mirex indicate that the chemical is associated with an increased incidence of liver tumor in rats and mice, which has led the U.S. Environmental Protection Agency to classify the chemical as a probable human carcinogen. Since mirex is strongly bioaccumulated in fatty tissue and very slowly eliminated, prolonged low level exposure may lead to significant body burdens.

Relatively few chemical disposal sites have been studied extensively over time or with thorough scientific vigor. Despite the identification of over 900 Superfund sites nationwide, fewer than 20 have been the subject of epidemiological or clinical research.[1] In most of these studies, only severe health outcomes such as cancer or serious birth defects have been selected for study, whereas the detection of increase risk for these conditions at sites such as Nease is unlikely for several reasons. Uncertain disease latency periods, small study population sizes and low prevalence of the diseases under study limit the power of findings in studies of cancer mortality among individuals exposed to toxic chemicals.[2] In most studies purporting to investigate associations with cancer, sample sizes are too small to demonstrate expected increases. As an illustration, in order to detect a doubling of relative risk with 80% statistical power at an alpha level of 0.05 for a cancer with a probability of one in one thousand in an unexposed group, an order of magnitude in which many of the the cancers sought after in toxic chemical exposures occur, a sample size of exposed and unexposed groups of 22,403 persons is required.[3] The most aggressive screening program would never yield a sufficient number of exposed persons at the Nease site to meet these criteria.

Another reason that cancer risk assessment at the Nease site is impeded is the lack of data sources for determining cancer incidence. In Ohio, unlike most major industrial states, cancer is not a reportable disease. There are few hospital-based registries in the area and they do not permit population-based

Matthew A. Stefanic, MPH,
Health Commissioner
Mahoning County

estimates of cancer incidence. County-wide mortality data are available but these do not reflect the experiences of residents most at risk nor are they sensitive to increases in cancer risk from environmental exposures such as the Nease site where disease latency periods are unknown.

Despite the limitations on epidemiological studies of toxic waste sites, many are arguing for the identification of as many mirex-exposed persons in Mahoning and Columbiana Counties as possible and for the creation of an exposure registry. These arguments are based on the principle that the community and individual have a right to know about potential health risks, even if these risks are currently inestimable. Several state agencies and citizens groups may consider petitioning the federal Agency for Toxic Substances and Disease Registry to conduct more screening and establish a registry. Meanwhile the investigation of the Nease site and the extent of area contamination continues. Salem-area residents must wait several more years before the EPA makes a decision on if and how to undertake a cleanup of the site and Little Beaver Creek. □

[1]Universities Associated for Research and Education in Pathology (UAREP). **Health Aspects of the Disposal of Waste Chemicals.** Bethesda, MD: UAREP, 1985.

[2]Janerich DT, Burnett WS, Feck G, Hoff M, Nasca P, Polednak AP, et al. Cancer incidence in the Love Canal area. **Science** 212:1404-7, 1981.

[3]Hatch M. Kline J, Stein Z. Power consideration in studies of reproductive effects of vinyl chloride and some structural analogs. **Environ Health Perspect** 41:195-201, 1981.

"Medical School: A Whole Different Outlook on Life"

The following speech was delivered by David Chuirazzi, M.D., Class of 1990, at the Northeastern Ohio Universities College of Medicine (NEOUCOM) Commencement on May 26, 1990. Dr. Chuirazzi grew up in Poland, OH, earned his B.S. degree from Youngstown State University, and is currently doing his residency in emergency medicine at Allegheny General Hospital in Pittsburgh, PA.

People often want to know what it is like to get through medical school. I can tell you that medical education is like a roller coaster of emotions and experiences. Therefore, I would like to spend my time relating some of these experiences to you.

For most of us, the road to becoming a physician began at either Youngstown State University, Akron University or Kent State. Those two years of undergraduate work seem to serve as a NEOUCOM boot camp; we studied biology, chemistry and physics and were told how difficult medical school would be. I noticed during this time everybody was secretly afraid that they would be told that they weren't smart enough to become a doctor—and be forced to live out the rest of their lives in West Virginia or something like that.

However, it was soon time to move on to that fertile crescent of corn and barley called Rootstown. I think that first year of medical school was the most stressful. There were many questions to be answered, for example: Will I flunk out? What is the Anatomy lab like? And, of course, is Dr. Taslitz really the Antichrist? One by one these questions were answered; and yes, we even got to know what a nice guy Dr. Taslitz is.

David Chuirazzi, MD

Somehow, we made it through the difficulty of that first year, and it was off to the second year of medical school. This is the year where you finally get to learn about all the different diseases. It was also the year I realized that I was a hypochondriac; because like many of my classmates, I thought I had every disease I read about. When we studied migraines — I got a headache. During the chapter on lung diseases — I thought I had tuberculosis. Of course, I was smart enough to just skip right over the chapter on impotence.

In spite of all my health problems that year, I survived to enter the Junior year, which is spent in the hospitals. I remember how nervous I was when I first started taking care of patients. In fact, I was traumatized the first day at the hospital when I was asked to get some blood from a patient. I didn't know what to do so I stood around the patient's room, waiting for him to fall and cut himself.

I'll never forget the first time in surgery, when the surgeon asked me to make the incision. I said to him, "Isn't there someone around here a little more qualified?"

Nevertheless, all these insecurities began to fade as we became more comfortable in the hospital setting. It seems we have come an amazing distance during the past year and one-half—all the hard work has paid off and we have become confident and competent medical students.

Even though I've joked about the various hurdles encountered in medical education, being in medical school has always been a very serious business to us. I'm very impressed at how much effort everyone has put forth, and I wish everyone successful careers.

On behalf of the entire class, I would like to thank the parents for their support. I would also like to thank the school for providing us with a superior education. I feel NEOUCOM is very unique, because after being together for six years, people become very close. I hope when we reflect on medical school, we don't forget the good times, the difficult times, or each other.

Thank you. □

In The News

Dr. James Anderson was re-elected alternate delegate to the AMA at the OSMA Annual Meeting, May 4, 1990.

Family Service Agency

The role of the family in current American life seems to have faced a major decline. We continually see broken families in the personal relationships of the people we see both on a professional basis and in our personal lives. At times the child without two parents seems the norm rather than the exception. Only seven percent of todays children are being raised in what was considered the traditional pattern of the mother at home. Families grow-up apart. Despite the seeming contradiction, there is often more, rather then less, dependence by adult children upon their parents. The custodial parent frequently needs the help of the grandparents. Those same grandparents are also providing for their parents in their declining years. The majority of elder parents are cared for by their children in some way. The family has changed, as is strongly evident.

"Only seven percent of todays children are being raised in what was considered the traditional pattern of the mother at home."

Individuals are going to be helped in the context of their relationship with others. The best treatment plan in the world will not work if it is sabotaged by the important people in the life of the patient or client. We face a challenge at times when we try to discover who is "family", but that connection is of major importance in a person's life. We have had teens with a terribly angry family where there seemed to be no hope of reconciliation. An alternate living arrangement was developed, and then the impossible family situation was worked out.

The Family Service Agency philosophy drives all the programs of the agency. This philosophy is that the family is central to working with clients. Most Family Service Agencies have a number of programs, and the Youngstown agency is no exception. Family Counseling, Unwed Mother Service with Adoption as an Option, Consumer Credit Counseling, Rape Victim Counseling, Services to Families in Industry, Daybreak Shelter for Runaway and Homeless Youth, and Foster Care for Teens are the major services provided by the agency. Because the agency strives to deal with the whole family, the agency service is interwoven in the community service. For example, the agency relationship with the medical community is extensive. Family and individual clients may need psychiatric hospitalization and the services of a psychiatrist. Agency caseworkers work with the health department family and child clinics. The Rape Counseling Program works in the emergency room with victims. The Consumer Credit program works with families who have lost control of their resources. Many of the people who participate in this program work out payment of medical bills with our credit counselors as they regain control of their family finances.

The agency adolescent programs are assisted in health screening of the runaway and homeless youth by the Ohio Nurses Association. The local hospitals are a resource for emergency care and hospitalization.

The concept of family care is critical to all that we do. Today there is a need to be creative in providing care to families for families have changed. Integration of the family agency into the community, including the medical community continues the belief that the family is an inseparable part of the community. The family is part of the strength of our country and our community, and is most important during these difficult times. □

Gerald Janosik, LISW
Executive Director

50 Years Ago — June 1940

Dr. Bill Skipp was president of the OSMA that year. He was a feisty bustling little man who was a bundle of energy. He was the first business manager of the "Bulletin", organized the Medical-Dental Bureau, served as Sixth District Councilor, and later was a delegate to the AMA from Ohio.

40 Years Ago — June 1950

The Democratic National Committee was circulating a booklet promoting President Truman's plan of universal health coverage. Locally, President Gordon Nelson reported that there was growing opposition throughout the country to government controlled medical care. He cited polls that showed that only ten percent of the voters were in favor of it.

New member that month was Dr. Fred Schellhase. Three deaths were reported: Dr. John S. Lewis, our first Urologist, Dr. Howard Miller, beloved family physician, and Dr. O.J. Walker, outstanding ENT specialist.

30 Years Ago — June 1960

Dr. Sam Goldberg was appointed to the Youngstown Board of Health to succeed Mrs. Dora Schwebel. Dr. John Stotler was also a member of the board. Drs. E.R. McNeal, Fred Coombs and J.P. Harvey went to San Francisco for the meeting of the American College of Physicians. Dr. Kurt Wegner attended a Symposium on Congenital Heart Disease in Philadelphia. Dr. Steve Ondash was installed as President of the Ohio State Surgical Association. Dr. John McDonough was taking special training at the Memorial Hospital in New York City.

Robert R. Fisher, MD

20 Years Ago — June 1970

President Dr. Bob Jenkins, with his usual farsightedness, wrote in his president's message that the membership should give serious thought to preparing the Society to become a contractual agent in the event that the government should come up with a comprehensive prepaid health plan. It was a good idea, but it's still just that; an idea.

Editor Dr. John Melnick, our resident historian, pointed out the many positive aspects of our community such as the Playhouse, the University, the Butler Art Museum, Mill Creek Park and Fellows Riverside Garden, to name just a few.

Dr. Winfred Liu was invited to lecture at the National Convention of the Canadian Society of Laboratory Technologists in Winnepeg. Dr. Kenneth Lloyd was elected a fellow in the American College of Physicians. Howard Remepes, our esteemed Executive Secretary, was elected President of the Association of County Medical Executives of Ohio.

New members that month were: for Associate Membership, LeRoy Bloomberg, M.D. and Ben C. Bonarigo, M.D. For non-resident membership was James S. Cho, M.D. of Warren.

10 Years Ago — June 1980

Dr. Oscar Turner submitted a short, concise article on the "Control of Increased Intracranial Pressure". It came complete with a chart to keep in your "pearl" notebook.

The Delegates gave a report on the Sixth District meeting in Cincinnati in May. Dr. Jack Schreiber was reelected as a delegate to the AMA. Dr. Schreiber also had some of his photographs on exhibit at the OSMA annual meeting.

Dr. Morris Deitchman died at 79, in San Clemente. He was a well loved internist in Youngstown for many years.

New members that month were: ACTIVE: Consuelo C. Albarran, M.D. ASSOCIATE: Joseph A. Fogarty, Jr., D.O., D.A. Hoffman, D.O., Abdur Rashid, M.D. and Clarence J. Shaffer, D.O. □

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Community Teaching Hospitals and Physician Related Issues

The community teaching hospital agenda must recognize and address a number of issues which might seem less directly related to Medicare Part A reimbursement but issues which could attack hospitals as significantly. The first of these issues relates to Medicare but is primarily aimed at Part B physician reimbursement.

"A further issue whichwill have a significant effect upon teaching hospitals is the regulation of resident work load."

In the Spring of 1989, HCFA issued a set of proposed rules on paying physicians in teaching settings. One of these proposals would offset against hospital costs any physician fees retained by the hospital. Specifically under the proposed rule, when a physician is compensated by a hospital for providing services which benefit patients in a general way, such as educational activities, and is required by the hospital to return a part of their revenue received for services to individual patients to the hospital, this portion will be treated as a reduction to the hospital's allowable cost for physician compensation. The final publication of these rules has not yet taken place and is not anticipated this year. In the recent budget reconciliation bill, Congress began the enactment of physician payment reform through the Resource Base Relative Value Scale (RBRVS) which will affect many of these definitions. However, the hospital payment offset language remains and is anticipated to remain there even after these regulations are eventually completed. As the Prospective Payment System has slowed the growth of hospitals Part A costs, the rate of growth for Part B physician costs has taken off. If these Part B costs continue to rise, teaching hospitals can expect increased administrative and congressional pressure to contain these costs. These efforts are bound to have an impact upon teaching hospitals and physicians receiving medical education reimbursement.

Gene A. Butcher, MD

A further issue whichwill have a significant effect upon teaching hospitals is the regulation of resident work load. The attack in this area has been primarily at the "State" rather than a "Federal" level. Beginning with the State of New York and spreading to California and other states as well as national accreditation agents and organizations, there has come a very strong movement to mandate an increase in the amount of supervision provided to house officers in teaching hospitals to reduce working hours in an effort to combat clinical errors caused by overwork and sleep deprivation. In the recent past, there has been emphasis upon attendings being credentialed and also being evaluated closely for clinical competency and clinical privileges. We can anticipate that similar efforts will be necessary for house officers particularly to document proficiency and also continued review of those privileges which a house officer may do after having been documented as proficient.

The progression of this issue has been relatively rapid. It is already clear that limiting resident's hours will have a cost penalty for all teaching hospitals who are aggravated by current and projected declines operating margin. Teaching hospitals will have the continued problems in recruiting against large university facilities which are better endowed but do not have the same level of primary care teaching opportunities.

In the State of New York, the inclusion of recommendations into resident accreditation process guarantees that there will be significant impact both on community and university teaching hospitals and provides clear implications for hospital fiscal concerns. In New York it was estimated that 400 additional attending physician FTEs were required to meet the supervision requirement and this would carry with it an estimated price tag of $40,000,000.

This issue began in response to a specific stimulus—the Libby Zion case

in New York. The reforming zeal which the New York legislature showed in creating these mandates has cooled somewhat because of the harsh reality of fiscal repercussions. The ongoing opposition of surgery and OB/GYN program directors particularly has slowed the implementation of these changes. While there are many ambiguities, hospital medical educators are best advised to be aware of the mandates from both political and accreditation authorities and to monitor carefully the cost associated with the compliance. Perhaps when the nature of projected costs are clear, relief may be sought through the legislative process, either in the form of offsetting finding or changes in these requirements.

These several issues above continue to provide challenges for the coexistence of the community hospital and quality graduate medical education programs. □

Installation of Officers Held

The Medical Society Auxiliary installation luncheon was held at the Tippecanoe Country Club on May 24, 1990.

Beth Bacani, the 1989 President, made farewell remarks. She thanked all who made her year a success. Challenges were proposed to members to remain committed to the volunteer work of the auxiliary and to stay involved with the auxiliary on the local, state and national levels.

The incoming officers were installed by a past president, Dolly Handel. She commended the women for their unlimited potential for advancing human welfare and for accepting leadership roles. The goals of the organization include a commitment to volunteering and to promoting well being in our community. The call to service was satisfied by Joan Abdu for corresponding secretary, Nancy Leonelli for recording secretary, Marcia Turocy for treasurer, Rose Mary Memo for vice-president and Pauline Sarantopolis for president-elect. The president for the 1990-91 year is Anita Gestasoni.

As Anita accepted the gavel and the president's pin she encouraged the auxiliary members to continue to support programs and projects of the Mahoning County Society Auxiliary, the Ohio State Medical Association Auxiliary and the American Medical Society Auxiliary.

Congratulations to all the incoming and outgoing members of the board of the Medical Auxiliary. May your year be filled with friendship and enjoyment as you serve the community. □

Rose Mary Memo

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Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and

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Swift and effective H_2-antagonist therapy

- *Most patients experience pain relief with the first dose[3]*
- *Heals duodenal ulcer rapidly and effectively[4,5]*
- *Dosage for adults with active duodenal ulcer is 300 mg once nightly (150 mg b.i.d. is also available)*

References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Clinical Laboratory Regulations

The proposed federal regulations governing all clinical laboratories were published in the Federal Register of May 21, 1990. These regulations will implement the clinical laboratory improvement amendments of 1988 (CLIA '88) which is public law 100-578. This document establishes three tiers of laboratory activity. The first tier requires a certificate of "Waiver" and will allow the performance of "simple tests" which HCFA has defined as those tests that have "an insignificant risk of erroneous result." Specifically, urine dipstick analysis, fecal occult blood, spun hematocrits, urine microscopic examinations, microscopic examination for pinworms or vaginal wet mount preparations, ovulation tests, urine pregnancy tests, full blood clotting times, C reactive protein, gram stains, KOH preparations on cutaneous scrapings, glucose screening by whole blood dipstick methods only, semen analysis, and slide card agglutination to include rheumatoid factor, anti-streptolysin, O screening and infectious mononucleosis screening only. "Level One" testing will allow only the following eleven tests which have been identified as having a reasonable risk of harm to the patient if the test is performed incorrectly, although the risk of erroneous results is minimized because the test methodologies are not complex. These test are: qualitative and semiquanitative determinations of cholesterol screening (not to include triglycerides and HDL cholesterol), culture for colony counts of urinary tract infection without identification or susceptibility testing, hemoglobin, white blood cell counts, red blood cell counts, hematocrit, BUN, creatinine, uric acid, glucose and direct streptococcal antigen test. "Level Two" testing will include any tests not identified in level one or in the waiver classification.

For the privilege of performing "Waiver Level" testing HCFA will charge $500.00 approximately every two years for an application form. For "Level One" testing HCFA will require a $2,000.00 application fee and standards which include evidence of proficiency testing as well as evidence that the director of the laboratory is either a physician or that he holds an earned doctoral degree from an accredited institution in an approved chemical, physical or biological science and be certified by a national accrediting board acceptable to HHS. The testing personnel must have earned an academic high school diploma or equivalent, have adequate training prior to performing tests on patient's specimens and possess a current license issued by the state in which the laboratory is located if such licensing is required. They must also have an understanding of specimen collection and handling, standard laboratory procedures and regulations, understand how to perform required preventive maintenance in calibration procedures for each test performed, be able to perform quality control, and be able to perform the tests and report the results accurately and reliably. The laboratory director for "Level Two" laboratories in most cases must be a certified pathologist. The "Level Two" technologist must essentially be a college trained person who has at least three years of academic study and preferably a bachelors degree in medical technology.

From these stringent criteria it is apparent that most physician office laboratories (POL) will not be able to function in the future in any way similar to their current level of operation. Most laboratory testing will be sent out and will require patient call back or second patient visits in order to interpret and address abnormal findings. This will add additional cost to the physician's office and ultimately to the total cost of health care delivery. Additionally, the inconvenience as well as the risk of delay in making diagnosis is apparent.

Fortunately, HCFA is inviting comment on these proposed regulations. Most physician organizations are supporting the concepts of quality assurance and proficiency testing in order to participate in Medicare supported laboratory activities. There is, however, sizeable opposition to the current lists of

Chester A. Amedia, Jr., MD

tests included in "Level One" laboratory testing activities and to the cost associated with obtaining certification for laboratory testing at the "Level One" activity.

If you disagree with these proposed regulations, you are encouraged to send your comments to HCFA and advise them of your opposition with constructive recommendations. A sample letter is printed below. Comments must be received no later than August 20, 1990.

Health Care Financing Administration
Department of Health and Human Services
ATTN: HSQ-176-P, P.O. Box 26676
Baltimore, Maryland 21207

RE: Proposed regulations implementing the clinical laboratory improvement amendments of 1988, public law 100-578

Gentlemen:

I am writing to comment on the proposed regulations for implementation of the clinical laboratory improvement amendments of 1988 (CLIA '88). The regulations outlined in volume 55 #98 of the Federal Register on May 21, 1990 have obvious good intentions, however many flaws are obvious to me as a practicing physician. I agree that for reasons of quality assurance of patient care, participation and proficiency testing is necessary and should be mandated. I also recognize the right and responsibility for Medicare and its representatives to inspect any laboratory performing work for Medicare beneficiaries.

I am, however, dismayed at the limitations of tests included in "Level One" testing. The omission of several studies including electrolyte panels (sodium, potassium, chloride and total CO2), general enzyme testing (AST, ALT, LDH, alkaline phosphatase), and testing for certain divalent ions (calcium, phosphorous, magnesium), as well as specialized lipid profiling (triglycerides, HDL cholesterol, and LDL calculations) and some miscellaneous tests (such as total protein, total bilirubin) will greatly hinder the practice of medicine as we know it today. Not only will the elimination of these studies from the usual office testing be a great patient inconvenience, but it will also cause a delay in recognition of many medical problems and likely in their treatment. Additionally, the delay in return of requested studies will likely cause additional burden to the practicing physician in requiring additional time to be spent calling patients back with abnormal results after they have been obtained, usually 24 to 48 hours after they have been seen in the office. Not only is this added inefficiency, but it will increase the cost of office practice. It is notable that there will be no savings with the above proposed regulations since these same tests will likely be referred with similar regularity to "Level Two" testing laboratories.

The laboratory testing equipment available to the practicing physician today is efficient and accurate. Many physicians use equipment similar to that currently employed in emergency rooms and in hospitals. The expertise necessary to operate this equipment is not as sophisticated as the "Level Two" laboratory requirements outlined in the above regulations. Certainly if a physician's office is able to maintain proficiency testing and accuracy as well as quality assurance activities consistent with the proposed regulations, then the tests outlined above should be permitted in a physician office laboratory (POL) and included in "Level One" activities.

Thank you for the opportunity to comment on the proposed regulations.

Sincerely,

(Your Name)

John Singer Sargent, 1856 - 1925
MRS. KNOWLES AND HER CHILDREN, 1902

Oil on canvas, 72" x 60"
Purchased by the Butler Institute, 1929

Mrs. Knowles and Her Children was painted in 1902, at a time when Sargent was besieged by clients. Even thought he was in constant demand as a portraitist he took infinite care with each painting, sometimes requiring as many as twenty-five sittings before the work was complete. One can only imagine the difficulty both the painter and the mother experienced in keeping two little boys entranced for a number sittings. According to a biographer, the boys were about six and four years of age when the portrait was done. They were aviators during World War I and both were killed. The mother, Mrs. Knowles, died in 1913.

John Singer Sargent was born in Florence, Italy in 1855. He was the son of a prominent Massachusetts family who had been engaged in the lucrative shipping trade since colonial times. Sargent's parents lived abroad, traveling from one European capital to another during the course of the social year. For the first eighteen years of his life, Sargent's family continued to travel throughout Europe. His mother fostered his talent in drawing and saw to it that he received periodic instruction, first from Carl Welsch in Rome and then at the Accademia di Belle Arti in Florence.

In 1874, the Sargent family settled in Paris. Sargent entered the studio of Carolus-Duran. Duran was an advocate of the new method of painting, teaching his students excellent drawing skills and insisting on artistic control over mass, tone and line. Sargent was able to combine a large, natural talent and a disciplined style with the skills taught by Duran and emerge, in the view of his contemporaries, as the culmination of American objective realism. Sargent's portrait of Duran brought him the beginnings of recognition and there followed the commission of half a dozen portraits which signaled the start of a successful career.

In 1885, Sargent moved to London, which was to remain his home for the rest of his life, although he continued to travel extensively in Europe and the United States. By 1890, Sargent was at the threshold of uninterrupted and unparalleled success. Considered the greatest portraitist of the Edwardian era, he was in constant demand on both sides of the Atlantic.

Sargent was extremely dictatorial in choosing his subjects and in how they would be portrayed on canvas. He insisted on complete freedom in the design, costume and setting for each portrait. He normally portrayed his subjects in their natural setting attired in reception or formal evening gowns.

By 1906, Sargent was declining most commissions for portraits. Having tired of the success of the fashionable portrait painter he turned to painting landscapes in water colors. A major endeavor of his later years was a series of elaborate mural decorations for the Boston Public Library. He worked on this massive projects for more than twenty years. He died in 1925. □

Prepared by Butler Curator, Clyde Singer

The following applications for membership were approved by Council.

Active:

Asad Azarvan, MD
Thomas S. Boniface, MD
Nancy L. Gantt, MD
Lawrence W. Handwork, MD
Louis J. Jacques, MD
Rani P. Krishnan, MD
Daniel L. Laufman, MD
Glenn J. Novak, DO
Laurence J. Soges, MD
Mehdi Soleimanpour, MD

Information pertinent to the applicants should be sent to the Board Censors.

Leonard F. Fagnano, MD
1920 - 1990

Dr. Leonard F. Fagnano, a former Youngstown surgeon died on June 22, 1990 at his home in Sun City West, Arizona. Dr. Fagnano who was 70, suffered a heart attack. He was a graduate of the Rayen School, Ohio State University and received his medical degree from Northwestern University College of Medicine. Dr. Fagnano had been chief surgeon for Republic Steel Corporation and was affiliated with the Youngstown Hospital Association retiring in 1980.

Joseph A. Fogarty Jr., DO
1935 - 1990

Dr. Joseph A Fogarty Jr., 55, a former medical director of the Mahoning County Board of Health, died of cardiac arrest on June 19, 1990 after a 2-1/2 year illness. A native of Kansas City, Missouri, Dr. Fogarty graduated from Rockhurst College, Kansas City and received his medical degree from the Kansas City College of Osteopathic Medicine. He came to Youngstown in 1967 and that same year accepted the chairmanship of the obstetrics department of Youngstown Osteopathic Hospital. He became a adjunct professor in obstetrics and gynecology at Ohio University. Dr. Fogarty held fellowships with the American College of Obstetrics and Gynecology and the American Foundation of Colposcopy and Colpmicroscopy. Active in the community he organized, with Youngstown State University Campus Ministry, the Cooperative Campus Ministry Free Clinic to serve downtown Youngstwon.

Francis G. Kravec, MD
1909 - 1990

Dr. Francis G. Kravec, died of a heart attack at the age of 80 on June 16, 1990. A life long resident of Youngstown, Dr. Kravec was a graduate of Austintown Fitch High School, Miami University and the medical school of Loyola University. He was a fellow of the the American College of Chest Surgeons and a member of the Emeritus Faculty at Youngstown State University. He was a past president of the Ohio Chapter of the America College of Chest Physicians. Semi retired from private practice, Dr. Kravec was the medical director for LTV Steel Company, Cold Metal Products Company and was a consultant in Chest Diseases at Woodside Receiving Hospital. In 1988 he received the Ohio State Medical Association 50 Years in Medicine award.

Advertising List

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Address Correction Requested